Discretionary Safeguarding Adults Review
'Daniel'

1. Introduction

1.1 The City and Hackney Safeguarding Adults Board (CHSAB) commissioned a discretionary Safeguarding Adults Review (SAR) following the death of Daniel on 30 May 2020.

1.2 Daniel was a 57 year old man, of white British heritage, who tragically ended his own life while homeless on the street, in spite of having had recent contact with police, homelessness and mental health services. He was classed as a '205' rough sleeper meaning that he was considered to be an entrenched rough sleeper. Daniel had been intermittently homeless for over 20 years, first coming to notice in Barnet in July 2001. Since 2012, Daniel had been living almost exclusively in the City of London and was well known to rough sleeping and outreach services in the area.

1.3 On 15 April 2020, Daniel was admitted to St Thomas' Hospital by a member of staff at St Mungo's, after he had expressed that he was going to take his own life. He was assessed by a duty doctor and reported to be experiencing suicidal ideation for twelve months. He highlighted feeling low due to the Covid-19 lockdown preventing him from making money, he felt that he was taken advantage of by others, and he missed having contact with his children and grandchildren. Unfortunately, there was a dispute in terms of where, location wise, to admit Daniel for inpatient care. However, Daniel stated that he would accept support and accommodation. A decision was made to discharge Daniel into hotel accommodation for an initial period of seven days with on-going support from the South London and Maudsley Hospital NHS Foundation Trust Home Treatment team.

1.4 Following Daniel's discharge from hospital, there was some initial contact with him however further attempts to engage proved unsuccessful. On 22 April, professionals were informed that Daniel had left the hotel. On 8 May 2020, Daniel was arrested for being drunk and disorderly. He received a Community Protection Notice, banning him from the City of London for three months on 9 May 2020. This prevented him accessing accommodation in the area. Despite this, a suitable hotel was located for Daniel however, attempts to engage him around this proved unsuccessful. Daniel responded to a message on 26 May 2020 querying why no one had contacted him. When professionals attempted to further contact him, Daniel did not answer. He was later found at Millenium Bridge having made an attempt to end his own life. Sadly, he was admitted to Royal London Hospital but passed away four days later on 30 May 2020.

2. Purpose of the Safeguarding Adults Review (SAR)

2.1 The CHSAB has a statutory duty to undertake SARs under section 44 of the Care Act 2014, which states that a SAR must take place when:

- An adult with care and support needs has died or suffered serious harm,

- the SAB knows or suspects that the harm was caused abuse or neglect, and
- there is reasonable cause for concern about how the Board, its members or others, worked together to safeguard the adult.

Where a case does not meet these criteria, the SAB has the discretion to commission a review, if it believes that there is learning to be gained in respect of how agencies worked together.

2.2 The purpose of a SAR is not to apportion blame on any individual or agency but to learn lessons to help improve the way that agencies help and respond to the safeguarding needs of adults with care and support needs. All partners involved in a review must cooperate by supplying information as requested and identifying lessons that can be embedded into practice.

2.3 A referral was made to the CHSAB's SAR and case review sub-group on 23 September 2020 by Adult Social Care, City of London Corporation in respect of Daniel. The referral observed that Daniel was an entrenched rough sleeper and known to a number of services across the City of London. It was queried whether having sustained accommodation may have supported Daniel to have his mental health needs met. Whilst the group felt that the case did not meet the threshold for a statutory review, it did acknowledge that there were grounds for a discretionary SAR. This was on the basis that there may be learning to be gained in terms of agencies responding to Daniel's vulnerabilities and multi-exclusionary homelessness.

3. Terms of reference

3.1 The following lines of enquiry were adopted for the review:

- How well services in the City of London work together to tackle multi-exclusionary homelessness
- How well services worked together to support Daniel
- Whether agencies sufficiently identified and responded to Daniel's vulnerabilities
- How well services in the City of London understand the intersections between substance misuse, anti-social behaviour and vulnerability
- The intersection between homelessness and suicide
- Any other safeguarding issues identified as a result of the review.

4. Methodology

4.1 A hybrid methodology was used for the review. It was agreed that the review should cover the lead up to Daniel's death as well as review his history of engagement with services. Agencies were requested to provide a chronology and review of their involvement with Daniel. The chronologies were combined and analysed by the Independent Reviewer.

4.2 A learning event with practitioners and operational managers known to Daniel was held. This was in order to gather views about his case and to clarify themes emerging

from the chronologies. The feedback from this event was incorporated into the analysis and recommendations to ensure that the review was informed by those more closely involved in Daniel's care.

5. Engagement with agencies

5.1 The following agencies provided reports to the CHSAB in respect of their engagement with Daniel:

- St Mungo's
    - The Lodge
    - Outreach team
- City of London Corporation
    - Adult Social Care
    - Community Safety team
- City of London Police
- Metropolitan Police Service
- Barts Health NHS Trust
- South London and Maudsley NHS Mental Health Trust
- Lambeth North Focussed Support Team
- Guy's and St Thomas NHS Foundation Trust
- Camden and Islington NHS Trust
- South West London and St George's Mental Health NHS Trust
- Oxford Health NHS Foundation Trust
- Adult Social Care, Wandsworth Borough Council

5.2 Efforts were made to obtain more information about Daniel's history from agencies he was engaged with. South West London and St George's Mental Health NHS Trust were able to confirm that Daniel had previously been in receipt of care from Oxford Health NHS Foundation Trust. Oxford Health NHS Foundation Trust was able to provide access to his historical records. By contrast, in Liverpool (his understood hometown), medical records are kept locally on a number of different sites, and it was not possible to obtain further information on his care. Attempts to locate Daniel's GP were also unsuccessful. Consequently, an understanding of Daniel's lived experience was largely provided by the police and voluntary sector agencies that worked with him whilst he was rough sleeping.

6. Family involvement

6.1 Unfortunately there was little reliable information about Daniel in relation to his background and upbringing. Efforts were made to contact family members, via voluntary sector agencies, known to Daniel. The Independent Reviewer attempted contact via email and telephone; however, this proved unsuccessful.

7. Parallel processes

7.1 There were no concurrent investigations during the SAR process.

8. Pen Picture of Daniel

8.1 According to Oxford Health NHS Foundation Trust, Daniel was brought up in Liverpool. He appears to have been married for 7 years until 2000, when he separated from his wife. He had 2 children, aged 23 and 24, whom he had not seen for many years. In 1999 he moved to Oxford where he slept rough for a few months until he was given council accommodation with Julian Housing. He said that, although street life was uncomfortable at times, it put him in touch with the "real meaning of life" and was a good means to communicate with lots of people.

8.2 Daniel had been intermittently homeless for over 20 years, having first been seen rough sleeping in July 2001 in the borough of Barnet. He was subsequently seen rough sleeping in a number of sites across London – he was seen to be bedded down (rough sleeping) 92 times in Barnet, Kensington and Chelsea, Lambeth, Westminster and The City of London. Since 2012 the street contacts with him appear to have been exclusively in the City of London, with the City of London outreach team. He was classed as a '205', a term used for a particular group of entrenched rough sleepers in London.

8.3 In 2012 he became accidentally involved in the Occupy London protest movement. He had an established sleeping space on the steps of St Paul's Cathedral at the time when the Occupy London protesters moved onto the same steps and stayed there for several months. He became the (fictional) subject of a play written at the time by Tim Price, called Protest Song – which was performed at the national theatre in December 2013: https://www.theguardian.com/stage/2013/dec/20/protest-song-review-national-theatre-london

8.4 Between 2013 and 2017 he had a housing association flat with additional tenancy support (from One Housing) in Battersea. This had been obtained through a clearing house tenancy (as part of the rough sleeper initiative commissioned by the Greater London Authority) and was part of a Personalised Budgeting project run by the City of London. This was designed to optimise choice for the recipient. The tenancy support was changed in 2016. His engagement was sporadic, but sometimes he would meet his housing worker more regularly. He had the same tenancy support worker throughout. There were times when he was not regularly living at the property and was rough sleeping in different parts of London. Daniel would be reported missing by friends and colleagues when he would go missing, leading to services spending substantial time trying to locate him. There were suggestions that he went back to Liverpool to get in contact with ex-wife and children, but there is no evidence to support this.

8.5 His flat was then taken over by other homeless individuals, and Daniel again became homeless until his death in 2020.

8.6 During this last period of homelessness, he stayed twice at The Lodge, a St Mungo's project in East London for entrenched rough sleepers with low support needs. His behaviour during these stays was, at times, quite unusual, with unexplained outbursts. This unusual behaviour was enough to raise staff concerns about whether he was suffering from an underlying mental health issue other than alcohol dependence.

However, this was not clarified and he does not appear to have been referred to community mental health services.

Contact with police

8.7 Evidence provided by the police described Daniel as pleasant when sober, but very unpleasant when drunk. The Police National Computer showed him as having made threats to slash and rape women although he was never reported to have assaulted anyone. He was picked up several times over the years for misbehaviour in public, often while intoxicated, but does not appear to have ever had a custodial sentence.

8.8 On 8 May 2020, Daniel was arrested after throwing traffic cones in the street. He was medically assessed twice and found fit to be detained. The next day he received a conditional discharge at Westminster Magistrates Court and was released. The pre-release assessment described him as an alcoholic who was refusing any treatment. He was given a 3 month Community Protection Notice (CPN) by the City of London Police, banning him from the City of London.

8.9 The establishment of the CPN appears to have been provided by the police alone, without the involvement of any partner agencies and without any attempt to achieve a multi-agency consensus. The usual protocol would have been for the CPN to be preceded by formal warnings. The way in which it was allocated on this occasion was unusual and seems to have been based on the single incident of risk to others, without reference to Daniel's mental state. He was not referred to any multi-agency meetings, such as the Community Multi Agency Risk Assessment Conference (community MARAC). In the event, the CPN seems to have undermined attempts to find emergency accommodation for Daniel. He was apparently very angry about this and threatened to hang himself in response to the notice. During the learning event with practitioners, it was highlighted that CPNs could be used to encourage and direct engagement with certain services.

Contact with mental health services

8.10 Daniel was known to three mental health services:

July 2007, Warneford Hospital, Oxford

8.11 He was admitted to hospital as an emergency after an overdose, understood to be triggered by relationship problems. However, it is of note that he was being prescribed Olanzapine, an antipsychotic medication, by his GP. He settled on the ward and was diagnosed with an emotionally unstable personality disorder and alcohol dependence. He underwent alcohol detoxification on the ward and was discharged after 2/3 weeks. He did not attend for follow up appointments.

20 August 2017, Springfield Hospital, London

8.12 Daniel was, on this occasion, detained under section 2 (an assessment section) of the Mental Health Act after having been found tying a noose to a lamppost. He was

diagnosed with alcoholism and psychosis secondary to substance misuse. He underwent an alcohol detoxification until 28 August 2017. He refused blood tests and an ECG on the ward and was discharged on 29 August 2017. Subsequent attempts by the community team to follow up with him were unsuccessful, this included an unsuccessful home visit. They reported him as a missing person, but he flagged down a police car a few days later to reassure them that he was OK.

2020, South London & Maudsley NHS Foundation Trust (SLAM), London

8.13 On 15 April 2020, Daniel was brought to St Thomas' hospital by a member of staff from St Mungo's who had found him on the Millennium Bridge stating that he wanted to kill himself. Their impression was that he probably needed to be detained under the Mental Health Act.

8.14 He was assessed in A&E, and it was decided that he needed further assessment of his suicidality, alcohol consumption and mood, as an in-patient. He did not seem to be averse to this idea, but problems arose about under which trust he should be admitted.

8.15 He had a GP in North London but most of his contacts with police and outreach services were in the City of London. This resulted in a substantial delay, during which he was transferred to a holding unit at the Maudsley Hospital, where he stayed overnight. He was re-assessed the following morning, on 16 April 2020 and his case was reviewed by a consultant psychiatrist during the afternoon. The psychiatrist felt that the Covid-19 situation, lack of beds, and degree of risk meant that risks of hospital admission outweighed the possible benefits. Daniel was therefore discharged to temporary accommodation, the Pasha Hotel in Camberwell, to be contacted by a Home Treatment Team.

8.16 The next day (17 April) he was phoned by a member of the Community Team South Lambeth Focused Support team. Daniel said that he was feeling better, not suicidal, and agreed to another telephone contact on the Monday. Although the team rang several times subsequently, this was the last time they were able to make contact with him. He subsequently left the hotel on 21 April, telling the hotel staff that he would not be returning.

8.17 5 1/2 weeks later, on 26 May, City of London police officers were called to the Millenium Bridge, where Daniel had hung himself from the south side of the bridge. Members of the public cut the rope and attempted to catch him on the foreshore, but he suffered serious injuries. He was admitted to the Royal London Hospital and died from multiple organ failure on 30 May 2020.

Contact with street services

8.18 Daniel had had regular contact with the City Outreach team for some years. They had helped him gain his accommodation in Battersea in 2013 and were involved in attempts to re-house him after he had left the Pasha Hotel.

8.19 A senior worker had met Daniel between 15-20 times whilst on secondment to the City Outreach team. He found him to be extremely likeable, engaging, and funny when sober. When drunk he would go to the Church at St Mary Aldermary on Watling Street where he would become abusive and refuse to leave. He noted that Daniel clearly viewed the City area as his area. His sister and a friend had apparently alluded to the fact that there were 'demons in life", which he did not like to discuss. It was never possible to identify these problems as he was unwilling to discuss any such problems

over the years, so it was not possible to form a view about what was driving his behaviours.

Observations on Daniel's needs

8.20 Daniel was a 57 year old man who had been homeless for about 20 years and who presented to both the police and mental health agencies. There is no clear insight into his upbringing or how he had become homeless in the first place. His drinking was always cited as an issue. Although there does not seem to be any clear evidence that he was dependent on alcohol it certainly seemed to have been involved in the episodes where he came to the attention of the police.

8.21 He expressed some odd ideas during his last two admissions to hospital but did not appear to be acutely psychotic. However, he was being prescribed antipsychotic medication before his admission to the Warneford Hospital and so there may have been prior contact with mental health services, of which we are not aware. Each contact with mental health services was precipitated by self-harm or suicidal ideas but, on each occasion, he appeared to settle quite quickly in a way that reassured mental health staff. However, his suicidal ideas do appear to have been present over a long period of time (or were, at least, recurrent) and were accompanied by a physical preparation, for example, the carrying around of a piece of rope.

8.22 He managed to maintain a distance from each of the agencies he was engaged with, hence the limited knowledge of his background and the difficulties that agencies found in working with him. His diagnosis, if any, was unclear despite his multiple contacts with mental health services.

9. Themes arising from the discretionary review

Localisation

9.1 Locally focussed services are best-placed to deliver services to homeless people such as Daniel. However, in his case, the importance of his local attachment may have been under-estimated. It is of note that on the only occasion on which he was re-housed in permanent accommodation, his accommodation was located in Battersea, although he spent most of his time in the City.

Cross Borough working and access to services

9.2 Prior to discharge from South London and Maudsley Hospital, attempts were made to place Daniel in in-patient care in two different locations. The first being Camden and Islington NHS Foundation, where his last known GP was based, who refused access to a bed and also to a hostel, on the basis that he was not confirmed as a resident. The second was East London Foundation Trust, which also refused to admit Daniel as a patient on their mental health ward. Consequently, he was discharged for follow-up by the South London and Maudsley Community Treatment Team.

9.3 It is recognised that mental health teams were under immense pressure during this period balancing the needs of admitting patients to support their mental health and also managing the risks posed by Covid-19. However, people experiencing multiple exclusion homelessness can often find themselves 'ping-ponging' between services due to their presentations proving difficult to address and challenges in terms of establishing their connections with specific areas. For example, Daniel was refused access to Camden and Islington's crisis house provision due to his alcohol dependency, but this was never formally diagnosed or recognised. The COMPACT document, providing guidance on hospital admission in London, further compounds this by containing ambiguous information relating to people who are of no fixed abode. It is important that professionals are familiar with legislative frameworks that exist, such as the Homelessness Reduction Act 2017 and the Human Rights Act 1998, to ensure that people experiencing multiple exclusion homelessness have equity of access to care and support.

Involvement of physical and mental health services

9.4 Daniel never appears to have had a cognitive assessment or thorough assessment of his physical health over the time that he was homeless. It was noted that Daniel had managed to stay for an appreciable period of time at the Lodge. The Lodge offered a low-intensity environment where he was able to stay without feeling pressured to change. This low-intensity approach may have worked against the active involvement of health and mental health services. It can be a difficult balancing act, especially for staff without a specialist health background. They need to weigh up the apparent necessity of discussing health issues with an individual, versus the likelihood of the individual leaving and disengaging if such discussions are pursued.

Exploration of underlying psychological issues and lived experience

9.5 There did not appear to be a full exploration of Daniel's underlying and psychological issues. This is evidenced by the lack of knowledge that professionals have around his lived experience. Understanding someone's lived experience can be invaluable in determining why they may be presenting in a particular manner. This is particularly helpful for adults with a history of non-engagement.

9.6 It was not clear how much weight was given to the challenges Daniel was currently experiencing in his life and how these impacted him, notably concerns in relation to the poor relationship he had with his daughter and grandchild and worries about Covid-19, both catching this and his inability to make money. Furthermore, it appears that Daniel had a history of making threats to end his life. There was potentially a missed opportunity to exercise professional curiosity to identify how these impacted his mental wellbeing and his suicidal ideation. The development of the Psychologically Informed Environment (PIE) approach may be a way of optimising the effectiveness of such projects. Visiting professional staff can help to reduce the sense of social distance from mainstream services and, perhaps, intimidation by them sometimes perceived by marginalised people. It appears that there would have been a role for both mental health and drug/alcohol services.

Access to specialist services

Physical

9.7 Access to health services for homeless people is a continuing problem. There is a dedicated GP service for homeless people in East London, The Greenhouse surgery. The challenge presented is that it is physically, somewhat inaccessible for residents; particularly those who may need support to engage. It is important that support is put in place to facilitate homeless people to engage and access services. It does not appear that Daniel was referred to a GP or supported to see a GP. However, this engagement may have provided another opportunity to reduce the risk of Daniel ending his own life.

Inter-service

9.8 Prior to his discharge, Daniel was assessed by a Consultant Psychiatrist, who noted that whilst he had chronic suicidal thoughts for around 12 months, he was not presenting with a particularly low mood and did not present with serious mental illness. Upon discharge, there were plans for the Community Mental Health Team to support him and he was also provided with the crisis line number for South London and Maudsley. The outcome of the assessment stated that Daniel would accept support and accommodation if this could be located. Unfortunately, the Street Outreach Service was not informed that Daniel had been discharged to the Pasha Hotel until after he had left this accommodation. There does not appear to be any attempts to engage Daniel with his GP. It is recognised that there are safeguarding risks associated with discharging people into temporary accommodation. The reasons for this are multi-faceted; often placements may not be appropriate for that person's needs and also lack the resources to deal with people's presenting physical and mental health needs. This represents a missed opportunity for multi-agency engagement and information sharing to ensure that Daniel's needs had been fully risk assessed but also to ensure on-going support and alternative accommodation upon his departure from the hotel.

Background information and history

9.9 Daniel's case is notable because of the sheer difficulty of getting any background information that may have informed the approach of social, housing, health services and the police. This highlights challenges with information aggregation between agencies – even within the NHS, where the NHS spine data offered little that was new or helpful. There was an opportunity for agencies to further consider best practice engagement and information with key agencies, where someone is engaging with a multitude of services.

Identifying need and vulnerability

9.10 It was unfortunate that the City of London Police did not identify the safeguarding risk pertaining to Daniel when he was arrested for being drunk and disorderly. Daniel was well known in the City of London, upon his arrest there was an opportunity to respond in a more holistic manner rather than using a crime enforcement approach. This would have provided an opportunity for agencies that knew Daniel to work together to put in place a plan to support him. Daniel was not referred to MARAC and they were not aware of the anti-social behaviour issues until he was issued with a Community Protection Notice. There was potentially a missed opportunity to undertake a multi-agency review into Daniel's needs and identify a more restorative and holistic response; particularly in the context of him having recently presented to services as feeling suicidal. The Community Protection Notice, regrettably, had the opposite effect by barring Daniel from an area where he had formed positive relationships with a number of services, who could have potentially addressed his on-going needs.

Gaps in engagement

9.11 Following Daniel's placement into Pasha Hotel, there is a gap in communication between Daniel and some of the key services involved in his care. Daniel was discharged from South London and Maudsley NHS Foundation Trust on 16 April 2020. There was engagement from the Lambeth North Focussed Support Team on 17 April 2020. There was no contact between Daniel and services between 18 April to 8 May 2020, when he was arrested by the City of London Police. Outreach services managed to locate Daniel on 22 May 2020, and he was provided with a phone so that he could stay in contact with them. Unfortunately, the team were unable to get in contact with him before he ended his life. During this time attempts were made to get Daniel alternative accommodation and provide him with a phone to engage with them, demonstrating good practice on behalf of the Outreach team. Mental health services contacted the Outreach team to let them know that he had left his accommodation. This led to the Outreach team putting an alert on the system so that other outreach teams would know he is missing and they also sent a risk assessment to accommodation services, Providence Row, to obtain alternative accommodation for him. There does not appear to be any further attempts from mental health services to engage with him, despite his recent discharge from hospital. Convening a multi-agency meeting when Daniel absconded from his accommodation may have been beneficial as it would have provided an opportunity to put in a strategy to locate and engage with him as well as escalate any risks relating to his situation.

10. Safeguarding Reflections

10.1 From the information provided, a safeguarding referral was never made for Daniel, in spite of his multiple risk factors: heavy drinking, possible mental illness, chronic or recurrent suicidal thinking and homelessness. This may have been due, at least partially, to the strongly independent and self-sufficient view that he seems to have had of himself and which he presented to other people. This was in spite of him having been discussed at the Rough Sleeper task and Action Group.

10.2 Whilst this approach may be understandable it does highlight the necessity for the involvement of health and social care professionals in helping to make such decisions. The implementation of the specialist mental health team for homeless people now exists in East London should make such involvement more accessible.

10.3 There may, in some cases, be the reluctance to involve statutory health agencies where someone appears to be very independent, for fear of alienating them even further from services. This is reasonable anxiety, but less likely to be an issue where health staff are regularly seen in environments providing services to homeless people or "part of the scenery" and able to demonstrate that they are able to be beneficial in supporting the individual.

11. Service Developments since Daniel's death

City Outreach Service

11.1 There is now a qualified social worker employed by the City of London Corporation Adult Social Care and Homelessness teams, to work with rough sleepers. Part-time psychotherapy provision has also been established. However, this is more orientated towards helping people adjust to the changes that occur when someone is coming off the street and moving into settled housing rather than helping someone to negotiate the initial stages of engagement with psychological (and other) services.

Multi-agency discussion forums

11.2 **Community Multi-Agency Risk Assessment** meetings are now more firmly established. Any agency can refer a client to these meetings, and they usually happen once a month – although an urgent meeting can be convened within about a week. The common reasons for referral centre around anti-social behaviour, crime, and suicidality.

11.3 There is a clearer route for escalating cases and improvements have been made to multi-agency discussions. The group has been working on clearer terms and indicators to consider, from the perspective of the local authority, where there is an issue in the community. The general view is that there is a move toward multi-agency discussion and consensus with some cases going to the community MARAC.

11.4 In relation to the **MARAC,** any agency working in the City, including commissioned services and the police, can refer to this panel, which includes representatives from both voluntary and statutory services. It meets once a month unless an urgent case arises in which case a meeting can be convened within 7 days. The primary goal is to problem solve and so any agency with an involvement in that case can be invited. The Panel considers cases involving anti-social behaviour, hate crime and suicide prevention. Multi-agency meetings have a low threshold entry point to discuss cases.

11.5 High risk cases were initially reviewed monthly and then moved to fortnightly meetings during the Covid-19 pandemic, as meetings became virtual. The Panel acts as a filtration system, with multi-agency oversight of what further referrals need to be made. Cases can progress to the complex cases panel and safeguarding referrals can be made, if necessary. This did exist at the time of Daniel's death but was not as effective. Subsequently, the systems have been reviewed and developed since the pandemic started; with practitioners reporting that the Panel works more effectively. It is important to note that the first 3-4 weeks of the pandemic were difficult for the Outreach team and an emergency response was managed by a small group of people (2-3 people) running the service as many staff were absent due to Covid-19.

11.6 The **dual diagnosis service** is provided by Turning Point, an alcohol and substance misuse organisation. The dual diagnosis service is outreach based and works on joint shifts with the street outreach teams. It has continued to grow over a year and a half and staffing has increased in response to an increasing demand during the pandemic.

Culture change

11.7 The participants at the learning event felt that there had been a significant culture change across the City of London over the last few years, generated by closer partnership working. There is now a greater emphasis on trying to understand a person's circumstances, taking into account their life story and seeking to understand their behaviour, rather than just offering an engagement and re-housing service. Daniel, and others like him, can become entrenched in rough sleeping for long periods of time rendering successful intervention less likely. However, adopting a more trauma informed approach to safeguarding can support more successful interventions with people experiencing entrenched rough sleeping.

12. Conclusions and recommendations

Localisation

12.1 Localisation of services is vital for those with a home and those without a home. The label “no fixed abode”, so often used in health services, is unhelpful as it implies the lack of local connections for those who are homeless. Re-housing options may be limited by the availability of appropriate housing in an applicant’s area of choice. But this is an important aspect of re-housing that needs to be fully taken into account. Where someone is rough sleeping efforts should be undertaken to ensure that they are facilitated to engage with health and social care services that are crucial to their wellbeing.

Recommendation 1: Both health (physical and mental) and social care services within the City of London should review how the concept of localisation is embedded within their service areas; particularly in relation to rough sleepers.

Recommendation 2: The City of London Corporation should undertake a ‘temperature check’ and engage with rough sleepers to assess how accessible key health and care services (ie. primary care, mental health, housing, substance misuse) are for them.

Police and judiciary

12.2 There were concerns regarding the allocation of a CPN to Daniel. This represented a lost opportunity for both police and other interested agencies to come together in a multi-agency way to identify how best to work with him, rather than exclude him from the City of London.

Recommendation 3: There should be a review of the following:

- ***a. Level of communications from the police to partner agencies, such as the street outreach team regarding rough sleepers.***
- ***b. The active and continuing engagement of police with these services.***
- ***c. How to use anti-social behaviour legislation in a way that helps to address issues rather than merely moving someone on to another geographical patch. There will be different ways to achieve such outcomes. For example, these could include a requirement to consider engagement with local services rather than being moved away from them.***
- ***d. CPN decision making and involvement of other agencies (in this case it seems to have been unilaterally decided by police rather than being the outcome of a discussion with all the agencies involved).***
- ***e. Wider consideration of the range of possible interventions that could be options for more appropriate court disposals. (These would include Alcohol Treatment Requirements and Mental Health Treatment Requirements. Such provisions aim to help the individual to manage their behaviour and so to reduce offending.)***

Recommendation 4: The City of London Corporation should audit how well multi-agency meetings with rough sleepers are working and check that the correct people are being referred to these meetings.

Mental health services

12.3 There may have been an issue with how seriously the A&E psychiatric staff took the concerns of the outreach worker who accompanied Daniel to St Thomas's Hospital. However, the worker involved reported that there concerns about suicidal intent were taken seriously. Those attending the learning event felt that outreach workers are still generally not held in particularly high esteem by health and mental health services. SLAM has two mental health teams for homeless people. However, one is an outreach service for those not in touch with services, the other focuses on appropriate discharge for homeless patients. Daniel did not fit well into either category, so neither service was directly involved with him.

12.4 This was echoed in terms of the reported under-recognition of the information provided by the voluntary sector. This was evidenced by the outreach team not being informed that Daniel was to be moved to the hotel. They did not find this out until they were informed that he had left the hotel, leaving several days when an intervention from the outreach team could have been implemented.

12.5 At the time of Daniel's contacts with services, The City of London and Hackney area did not have a specialist mental health team for homeless people, and it might have helped if there had been closer contact between mental health services and the outreach team.

Recommendation 5: Management within the mental health trust should examine the options for outreach staff to provide consultancy input to the trust or direct clinical input in cases involving rough sleepers. At present, there has been a specialist rough sleepers team within the East London Mental Health Foundation Trust, the Rough Sleeping and Mental Health Programme (RAMHP), although its future has not been decided; this might well be a good place to embed this process.

Recommendation 6: Daniel's case should be discussed at a weekly academic meeting at the Maudsley Hospital, which generally attracts a substantial audience of junior doctors.

London compact document for allocating responsibility for mental health admission

12.6 Unfortunately, the implementation of the London Compact did not work well for anybody, resulting in a delay of several hours before SLAM accepted responsibility for Daniel's continuing care. The Compact provided a number of case studies outlining best practice for engagement with service users. None of the "no fixed abode" examples in this document are registered with a GP. Daniel was registered with a GP, although it was not easy to establish who this was or whether he had had on-going engagement with his GP.

12.7 The information provided within the London Compact is conflicting at times, with one example of someone with no GP, no address and no local connections being admitted to the area where he has presented. Another example, again with no GP, is of a person who was admitted back to the area where she has been previously known to services. The last example is where the patient has no address and no GP and provides no further information about themselves. Again, they are to be admitted to the service where they have been presented.

12.8 The underlying assumption seems to be that a homeless person, almost by definition, will not be registered with a GP. The implicit assumption, where someone is registered with a GP, is that they have a significant local connection there, which, in this case, was not so.

Recommendation 7: Both SLAM and the City and Hackney Safeguarding Adults Board should provide feedback on the problems outlined above and escalate to NHS England and NHS Improvement the concerns about the London Compact.

Recommendation 8: Professionals working with people in the City should ensure that all residents being discharged from mental health services are referred to their GP post-discharge. Where an individual does not have a GP, they should be supported to register with a GP.

Homelessness services

12.9 The efforts of the outreach service to provide a continuing service to Daniel were undermined by poor communications from both the police and the mental health service. This may be improved by more formal arrangements for continuing contact, perhaps in the form of a service level agreement.

Understanding lived experience

12.10 There was a limited understanding of Daniel's lived experience despite efforts from the outreach team to meaningfully engage with him and build rapport. Understanding someone's lived experience is highly beneficial in identifying their needs and building long-term sustainable relationships with people who have complex needs. Adopting a trauma informed approach to safeguarding can support practitioners to build this rapport with service users. It is important the practitioners are supported to develop this approach in their work.

Recommendation 9: SLAM and East London Foundation Trust should look at the principles of the Psychologically-Informed Environment (PIE), where the input of clinical psychologists is built into the normal functioning of the project.

Recommendation 10: All partners in the City of London should ensure that professionals working with rough sleepers are aware of and trained in strengths-based and trauma informed approaches to safeguarding.

Risk management in cases with suicide risk

12.11 Appropriate risk assessments were undertaken in respect of Daniel prior to his discharge into the community by mental health services. It is unfortunate that there was an extended period of time where Daniel was not engaged with or seen by professionals between him leaving temporary accommodation and his death. Daniel was only reported as a missing person by homelessness services. This was not escalated as a concern by any other agency, despite Daniel reporting to feel suicidal. It is recognised that this was during the peak of the pandemic when services were contending with an unprecedented situation and learning to adapt services to this. However, moving forward there may be opportunity to review discharges from mental health services to ensure that there is robust support available to those that may pose a suicide risk.

Recommendation 11: Health and social care teams based in the City should assure themselves that multi-agency risk assessments are in place where

residents are discharged from mental health services into temporary accommodation.

Recommendation 12: A protocol should be put in place in the City where people who are rough sleeping go missing. This should include a checklist of when cases should be escalated to senior management or the police.

Recommendation 13: Both health and social care professionals working in the City of London should put in place regular (as agreed by the service user) check-ins for residents known to have significant concerns around sucidal ideation. These check-ins should remain in place until such a point that professionals are satisfied that the individual's suicidal ideation has been risk assessed and managed.

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